Michigan Department of Community Health

Children's Special Health Care Services

INCOME REVIEW/PAYMENT AGREEMENT AMENDMENT

Purpose: CSHCS representative provides review/admendment to client.

Local Health Department Name	LHD Staff Name and Title

Regarding:

Client Name	Client ID Number
Period of Coverage **From:** **To:**	Adult Client or Legally Responsible Party

Original Agreement and Reason(s) for Changing that Agreement:

Original Agreement Amount: $ _____ per month **X 12** (months) **= $** _____ total

The original payment agreement has been changed for the following reason(s):

☐ Change in family **size (new size _____)** effective date: ..... _____

☐ Change in family **income (new income amount $ _____)**, effective date: ..... _____

☐ Death of Client, date: ..... _____
Note: *No calculation is needed – Results in zero balance to outstanding payment agreement.*

☐ Client has Medicaid, WIC, or MIChild, effective date: ..... _____

☐ Other (explain): _____

New Agreement Co[illegible]ut[illegible]io[illegible]a[illegible]l [illegible]o[illegible]va[illegible] Please adjust the account accordingly.

From _____ [illegible] $ _____ per month **X** __ (months) **= $** _____ .

From _____ T[illegible] $ _____ per month **X** __ (months) **= $** _____ .

Total New Obligation **= $** _____ .

- The changes shown above are true and complete to the best of my knowledge.
- I approve of the changes in the new payment agreement as shown above.

Signature of person who signed the original agreement — Date Signed

Mail the completed Amendment request to:

MDCH/CSHCS
Customer Support Section
P.O. Box 30734
Lansing, MI 48909-8234

AUTHORITY: Act 368, P.A. 1978.
COMPLETION: Is Voluntary, but required if CSHCS program services are desired.

MSA-0927 (11/05) Previous editions are obsolete.

Distribution: - Original - CSHCS
- Copy - Parent/Guardian
- Copy - LHD